Title: Youth mental health in deprived urban areas: A Delphi study on the role of the GP in early intervention.

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Abstract:

Background: GPs, as healthcare professionals with whom young people commonly interact, have a central role in early intervention for mental health problems. However, successfully fulfilling this role is a challenge, and this is especially in deprived urban areas.

Aims: To inform a complex intervention to support GPs in this important role, we aim to identify the key areas in which general practice can help address youth mental health and strategies to enhance implementation.

Methods: We conducted a modified Delphi study which involved establishing an expert panel involving key stakeholders / service providers at two deprived urban areas. The group reviewed emerging literature on the topic at a series of meetings and consensus was facilitated by iterative surveys.

Results: We identified 20 individual roles in which GPs could help address youth mental health address youth mental health, across five domains: 1. Prevention, Health Promotion and Access, 2. Assessment and Identification, 3. Treatment Strategies, 4.Interaction with Other Agencies/Referral, and 5. Ongoing Support. With regard to strategies to enhance implementation, we identified a further 19 interventions, across five domains: 1.Training, 2. Consultation Improvements, 3. Service-Level Changes, 4. Collaboration, and 5.Healthcare-system Changes.

Conclusions: GPs have a key role in addressing youth mental health and this study highlights the key domains of this role and the key components of a complex intervention to support this role.

Introduction

Addressing mental health and substance-use issues among young adults is a population health priority in Ireland. Among 17-25 year olds, depression (28%), anxiety (29%), problem alcohol use (61%) and problem substance-use (45% cannabis use) are common problems [1]. This is especially the case in deprived urban areas where mental health and substance-use issues are more common and associated with considerable adverse health and social outcomes [2-4]. Youth from these areas are often defined as 'at risk', due to the environment's negative effects on childhood development resulting in increased likelihood of developing mental health, substance-use, and criminality issues [5].

Early intervention for youth mental health is considered easier and more effective than traditional approaches to treatment [6]. As a gatekeeper to care and because of the ongoing support it offers, primary care is well placed to facilitate early intervention. However, GPs may encounter obstacles to making referrals for youth mental health issues [7]. Lack of referral options, the stigma associated with mental health services and families' preferences to obtain mental health interventions in primary care [8], suggest general practice is likely to have an increasingly important role for youth with mental health issues [9]. Indeed, current mental health policy in Ireland advocates a primary care model of treatment [10].

However, one third of children and youth referred to specialist mental health services do not make contact with primary care [7] and although mental health problems are common (31-39%) among young people attending general practice, most cases are neither diagnosed nor actively treated [11]. In Ireland, a ten year follow-up study of 11 year olds from the Dublin area found that while one fifth had symptoms indicative of a probable psychiatric condition, only a minority had received any formal medical/psychiatric intervention [12]. The reasons for this are complex: emotional distress is not always viewed as a medical problem by young people [13] and GPs may worry about 'medicalising' adolescent behaviours and mood [14]. Patients believe that GPs lack training in mental health, will be dismissive of them, will not offer 'talking therapy' and that a prescription of anti-depressants is the most likely outcome [15].

Relevant clinical guidelines do exist and may help primary care to identify and treat mental and substance-use disorders among young adults. However, as shown in Table 1, an outline of these guidelines and their applicability to various settings and populations shows that many of these guidelines have limited value in primary care: Some have been developed for secondary care or specialist mental health services [16, 17], and many also relate to either adult or children populations, and thus do not enlighten our approach to issues specific to the care of young adults [18-20], e.g. changing behaviour, confidentiality, consent. These guidelines present a large and difficult to synthesise volume of information on many aspects of the care of young people with mental health and substance-use issues, which unfortunately is not practical in the busy general practice setting.

In addition, though many of the guidelines assume referrals to other agencies such as specialist mental health services and especially psychological treatments are possible, in practice this may not be the case [21]. This is especially true of services in Ireland, where only cases marked 'urgent' are immediately treated by CAMHS. Those with more 'routine' problems are put on waiting list, most of which are seen in three months, but it has been previously reported that 22% of new referrals waited from three months to over a year to be seen [22].

As part of a larger programme of research to develop a complex intervention to enable primary care address youth mental health in deprived urban areas, this paper aims to describe the key elements of the GP's role in the care of these issues by establishing a multidisciplinary, expert stakeholder panel from two of Ireland's most deprived urban areas.

< Table 1 >

Methods

Rationale for approach

One way to determine which key area the GP should address is to gather expert opinions systematically. Formal consensus methods offer an ideal means to do this. These methods have been defined as "group facilitation techniques designed to explore the level of consensus among a group of experts by synthesising and clarifying expert opinions" [23]. Their main purpose is to define levels of agreement on different subjects by a group of experts. On many important health issues, there can be a relatively small group of acknowledged experts whose knowledge and opinions can guide best practice in relation to the issues of concern; sometimes a large survey would not be appropriate [24]. Formal consensus methods have become more common as tools for solving problems in health and medicine, and particularly mental health [25-27] and primary care practice [28-30].

In the area of youth mental health, the approach has been used to create quality standards for child and adolescent mental health services in primary care [31]. An expert panel of service providers and carers of children with mental health issues identified 10 indicators of quality care for young people with mental health presentations in primary care. These items focused strongly on parental involvement, and how to establish quality relationships with parents and young people in primary care. However, the results do not aid the identification of young adults with mental health problems, and assumes parental involvement. Many young people present in primary care without parents: in urban deprived areas, some parents may be struggling with their own mental health and substance-use issues, or indeed may be incarcerated or deceased. Furthermore, young persons may prefer to present without a parental accompaniment, or may not even initially present with a mental health difficulty.

As such, it remains important to establish how GPs in these particular locations may best identify, treat and engage young people who may have substance-use or mental health issues. We used a modified Delphi Technique as developed by Listone and Turoff [32].

Establishing the expert panel

It was necessary that participants displayed not only expertise in the area of youth mental health and clinical practice, but also knowledge of the specific psychosocial issues and problems of Dublin South Inner City and Limerick City. We chose the Delphi method specifically for this research to create a space for individuals working in these localities to interact and discuss a problem that is important to them and the community. It was envisaged this exchange of ideas and experience could produce secondary gains, specifically enhanced interaction between professionals, service providers from different disciplines. We also hoped to positively influence current work practices with young people in primary care by familiarising service providers with up to

date literature, and our previous research findings on how young people experience current services in Limerick City and Dublin South Inner City [33].

We sought experts who were working in primary care (general practice / practice nursing / wider primary care teams), secondary care (addiction, CAMHS, Adult Mental Health) and local community youth agencies. Personal recommendations were sought from members of our research steering group for individuals working in these services who would have sufficient knowledge to be considered an expert for this group. Secondly, members of the Ireland's Association of Child & Adolescent Mental Health (ACAMH) affiliated Youth Mental Health Special Interest Group were invited to participate or to recommend colleagues who might be approached. Thirdly, a number of individuals working in primary care in the two localities were contacted and informed of the study. They were invited to take part if they agreed that they had the required knowledge of youth mental health needed to participate.

In all, 29 experts were nominated to participate in the study from a range of disciplines, specifically: General Practice, Primary Care, Addiction Services, Child & Adolescent Mental Health (CAMHS) Services, Community Mental Health Services, and Community Youth Services). A stratified random allocation approach to sampling was then adopted; possible participants were allocated to groups and a quota sampled from each group to a total of 17 (see Table 2). Each panel member selected was then formally invited to participate, given background information on the project and invited to attend one of two meetings in either Dublin or Limerick.

Consensus procedure

Initial plenary meetings were held in both centres in both cities. Experts were asked to suggest ways general practice could address youth mental health and substance-use and how these could be possibly implemented. These meetings were then followed by two iterative surveys of the expert panel on what to include in an intervention and how to implement it in practice. The first survey fed back the data created in the initial meetings, and asked the panel to indicate any areas needed for an intervention that may not have been included previously. The second survey then asked panel members to rate these items in terms of how strongly they agreed that they should be included in any intervention created (Strongly Agree, Agree, Disagree or Strongly Disagree) in order to gain a consensus on what should or should not be included. The results of this survey were then fed back to the panel and followed by a final meeting conducted by phone-conferencing methods with the entire expert panel. This involved discussing the emerging findings, possible ambiguities and established group consensus. A diagram of the full procedure in more detail is outlined in Figure 1.

Ethical approval for this study was granted by the Research Ethics Committee of the Irish College of General Practitioners.

< Table 2 >

< Figure 1>

< Figure 2 >

Results:

We identified 20 areas that should be addressed in general practice or primary care, listed with their ratings (see Table 3). There was little variation between the importance of each item, although 'How to best identify mental and substance-use disorders', 'Mental health assessment and substance-use explored as part of holistic assessment', 'Preventative health', 'Referral pathways', and 'Inter-agency collaboration' had near universal strong agreement on their importance in identifying and treating youth mental health in primary care .

We identified 19 items which would support the implementation of the above youth mental health and substance-use interventions (see Table 4). Similarly, there was little variation between the rating of importance for each item, although 'Access to services', 'List of appropriate agencies', 'Creating appropriate time and space to explore the young person's issues', and 'Which interventions can be initiated in primary care / general practice' had near universal agreement on their importance for implementing interventions for youth mental health in primary care.

After the second meeting of the expert panel it was concluded that while all the items were important to include in any general practice based intervention, they might best be presented under five headings (see Box 1):

- Prevention / Health Promotion / Access
- Assessment and Identification
- Treatment – pharmaceutical, psychological and other approaches (exercise, diet, etc).
- Interaction with Other Agencies / Referral
- Ongoing Support

Similarly, we could group the implementation recommendations under the following headings (see Box 2)

- Training
- Consultation Improvements
- Service-Level Changes
- Collaboration
- Healthcare-system Changes

< Table 3 >

< Table 4 >

< Box 1 >

< Box 2 >

Discussion

Key Findings

We identified diverse ways in which GPs can help address the challenge of optimizing youth mental health in deprived urban areas and these span the areas of prevention / health promotion / access, assessment / identification, treatment, interaction with other agencies / referral and ongoing support. While these headings may seem self-evident to the practicing GP, no current guidelines on how great or small a role the GP should be taking exists. Furthermore, while GPs feel they lack training at both the undergraduate, postgraduate and continuing professional development level, and therefore have little confidence in their ability to detect and/or treat mental health problems in young people [33], our findings suggest the domains which might form the focus of future training efforts.

The findings also suggest ways to implement this role in practice through changes in service structures, reflecting current practice and the issues affecting the GP in an Irish, socially-deprived context. These findings show how current Irish mental health policy can be enacted. Changes need to happen on a number of different levels, be it through improved agency collaboration and communication, providing stepped-care within the health service, or offering youth friendly primary care services which can give the time and space to work with these issues. Guidelines on how to interact with other services would also be a useful first step in order to increase sharing of information and create smoother transitions through care [34].

Findings in relation to previous literature

Previous research and guidelines have addressed many of the above. In particular, Anderson and Lowen [35] relate similar ideas in relation to ongoing care, and going above and beyond what is usually expected from the GP to ensure that the young person‘s needs are met. A number of different guidelines for youth friendly services also recommend improving links between schools and other youth services within a locality, ensuring confidentiality and consent factors are understood by all staff, and providing psychological support [36-38]. NICE guidelines on treating common mental health disorders also support many of the implementation factors, such as plain English use, collaboration between services. In particular it is recommended to share information to ensure patients are being referred to appropriate services, and then are fully supported once they attend. [39]. Opportunistic screening is also recommended in primary care [36, 40], with every presentation of a young person considered a good time to talk about mental health or substance-use.

Methodological Considerations

The modified Delphi method ensured that all panel members were presented with and familiar with the literature and reading material; as much information as possible was collected from the expert panel; and the panel were able to interact, creating wider discussion and generating more ideas. The creation of the expert panel also gave the opportunity to professionals working in the same area with similar goals to interact with each other and potentially form new connections which could aid their working practice in future. Furthermore, this panel reflected a large number of different disciplines who work with young people in a number of different settings. This meant there was a wide knowledge base through which to discuss how to best approach and work with young people.

It could be argued that by doing a modified Delphi, the group situation favoured some voices over others. However, the two questionnaires were administered anonymously, in the hope that if the group discussion had

silenced some voices, all opinions could therefore be expressed in the survey. Another potential weakness is that fully controlled feedback of answers to each round (where each participant is told how their ratings compared to others) was not provided in this study, and there were only two rounds used, one of which was a group meeting, in order to establish consensus on items. This means that any ratings established in the first survey may not have been truly considered before the second consensus meeting, and the meeting situation may have further moved individuals away from their original rating. However, considering that all items made consensus for inclusion in the guidelines in the first round, with very little differentiation between each item in terms of approval, it seems unlikely that any panel member would have changed his or her mind to consider any item unsuitable for inclusion: As there was hardly any disagreement on inclusion for items, there was less opportunity for a strong proposal of exclusion for any item.

Implications for Research and clinical practice

There are currently no guidelines available which explore the full nature of the role that general practice can play in youth mental health and substance-use issues to this extent. However, due to the busy nature of general practice, especially in an urban setting, the practicality of creating a document akin to guidelines that addresses all these domains is reduced: The document would be unwieldy, lengthy, and unlikely to be of use to the busy GP. Certainly time pressures prevent GPs from using guidelines [41, 42], and in order for guidelines to be incorporated into use, they must be applicable to their setting [43]. We therefore posit it would be more valuable to create a specified professional development course for identifying and treating youth mental health based on this above findings. This course would be available for all GPs and address many of the above headings, including how to conduct holistic assessment, information on confidentiality and consent, recommendations for practice changes, recommendations for service interactions, and recommendations on how to make referrals. This course could be based on current best practice, and be tailored to the educational needs of the practicing GP and enhance GPs confidence in their ability to address youth mental health.

It is evident that health professionals working in youth mental health and addiction are keen to improve the role of primary care within this field, establishing the potential of the GP practice to take a lead in early intervention and help young people who are not currently receiving the services they need. These findings highlight the varied roles that general practice and primary care teams can fulfill in order to aid early intervention, as well as offering guidance on how certain changes within the current system would be a good starting point for initial improvements in caring for young persons. As, such, this data provides a key foundation into the creation of a complex interventions for improving care for young people in deprived urban environments. Most importantly though, these findings indicate there is a responsibility on GPs to talk to young people about mental health and substance-use, and take a greater role in addressing these problems. By taking a more active role across the domains identified above, and incorporating the recommended actions into practice, GPs can help to greatly improve the lives of these young people, as well as lead primary care in taking a greater role in mental health treatment.

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